General Assembly

Bill No. 6722

January Session, 2001

LCO No. **3716**

Referred to Committee on Public Health

Introduced by:
REP. WARD, 86th Dist.
SEN. DELUCA, 32nd Dist.

AN ACT CONCERNING HOSPITAL FINANCE AND DATA REPORTING.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (a) of section 19a-612c of the general statutes is repealed and the following is substituted in lieu thereof:

(a) On and after July 1, 1995, wherever the word "commission" is used or referred to in the following sections of the general statutes, the word "office" shall be substituted in lieu thereof and whenever the words "Commission on Hospitals and Health Care" are used or referred to in the following sections of the general statutes, the words "Office of Health Care Access" shall be substituted in lieu thereof: 1-84, 1-84b, 12-263a, 17a-678, 17b-234, 17b-240, 17b-352, 17b-353, 17b-356, 19a-499, 19a-507, 19a-509b, 19a-535b, 19a-633, **[**19a-635, 19a-636,**]** 19a-638 to **[**19a-650, inclusive,**]** 19a-639d, inclusive, 19a-641 to 19a-647, inclusive, 19a-649, 19a-653, 19a-654, as amended by this act, 19a-660 to 19a-662, inclusive, 19a-669 to 19a-671, inclusive, **[**19a-674 to 19a-679, inclusive**]** 19a-676, 19a-677 and 19a-679, as amended by this act.

Sec. 2. Section 19a-637 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) In any of its deliberations involving a proposal, request or submission regarding **[**rates or**]** services by a health care facility or institution, the office shall take into consideration and make written findings concerning each of the following principles and guidelines: The relationship of the proposal, request or submission to the state health plan; the relationship of the proposal, request or submission to the applicant's long-range plan; the financial feasibility of the proposal, request or submission and its impact on the applicant's rates and financial condition; the impact of such proposal, request or submission on the interests of consumers of health care services and the payers for such services; the contribution of such proposal, request or submission to the quality, accessibility and cost-effectiveness of health care delivery in the region; whether there is a clear public need for any proposal or request; whether the health care facility or institution is competent to provide efficient and adequate service to the public in that such health care facility or institution is technically, financially and managerially expert and efficient; **[**that rates be sufficient to allow the health care facility or institution to cover its reasonable capital and operating costs;**]** the relationship of any proposed change to the applicant's current utilization statistics; the teaching and research responsibilities of the applicant; the special characteristics of the patient-physician mix of the applicant; the voluntary efforts of the applicant in improving productivity and containing costs; and any other factors which the office deems relevant, including, in the case of a facility or institution as defined in subsection (c) of section 19a-490, such factors as, but not limited to, the business interests of all owners, partners, associates, incorporators, directors, sponsors, stockholders and operators and the personal backgrounds of such persons. Whenever the granting, modification or denial of a request is inconsistent with the state health plan, a written explanation of the reasons for the inconsistency shall be included in the decision.

(b) Any data submitted to or obtained or compiled by the office with respect to its deliberations under this section and sections **[**19a-635 to 19a-640**]** 19a-638 to 19a-639d, inclusive, with respect to nursing homes, licensed under chapter 368v, shall be made available to the Department of Public Health.

[(c) Notwithstanding the provisions of subsection (a) of this section, the office in its deliberations under section 19a-635, 19a-636 or 19a-640, shall not direct or control the use of the following resources of the hospital concerned: The principal and all income from restricted and unrestricted grants, gifts, contributions, bequests and endowments.**]**

Sec. 3. Section 19a-641 of the general statutes is repealed and the following is substituted in lieu thereof:

Any health care facility or institution and any state health care facility or institution aggrieved by any final decision of **[**said**]** the office under the provisions of sections 19a-630 to **[**19a-640, inclusive, or section 19a-648 or 19a-650**]** 19a-634, inclusive, or sections 19a-637 to 19a-639d, inclusive, may appeal therefrom in accordance with the provisions of section 4-183, except venue shall be in the judicial district in which it is located. Such appeal shall have precedence in respect to order of trial over all other cases except writs of habeas corpus, actions brought by or on behalf of the state, including informations on the relation of private individuals, and appeals from awards or decisions of workers' compensation commissioners.

Sec. 4. Subsection (a) of section 19a-643 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The office shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of sections 19a-630 to **[**19a-640**]** 19a-634, inclusive, sections 19a-637 to 19a-639d, inclusive, and sections 19a-644, as amended by this act, and 19a-645, **[**and 19a-648**]** as amended by this act, concerning (1) the submission of data by health care facilities and institutions, including data on dealings

between health care facilities and institutions and their affiliates, and, with regard to requests or proposals pursuant to sections 19a-638 and 19a-639, by state health care facilities and institutions, **[**the ongoing inspections by the office of operating budgets of health care facilities and institutions after their approval,**]** and (2) standard reporting forms and standard accounting procedures to be utilized by health care facilities and institutions. **[**and the transferability of line items in the approved operating budgets of the health care facilities and institutions, except that any health care facility or institution may transfer any amounts among items in its operating budget, provided such facility or institution is not exceeding and will not exceed its overall operating budget. All such transfers shall be reported to the office within thirty days of the transfer or transfers.**]**

Sec. 5. Subsection (a) of section 19a-644 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) On or before February twenty-eighth annually, **[**each health care facility and institution for which a budget was approved or revenue limits were established under the provisions of section 19a-640 or section 19a-674,**]** for the fiscal year ending on September thirtieth of the immediately preceding year, each hospital licensed by the Department of Public Health shall report to the office with respect to its operations in such fiscal year, in such form as the office may by regulation require. **[**Said report shall include: (1) Average salaries in each department of administrative personnel, supervisory personnel, and direct service personnel by job classification; (2) salaries and fringe benefits for the ten highest paid positions; (3) the name of each joint venture, partnership, subsidiary and corporation related to the hospital; and (4) the salaries paid to hospital employees by each such joint venture, partnership, subsidiary and related corporation and by the hospital to the employees of related corporations. In addition, said report may, at the discretion of the office, include a breakdown of hospital and department budgets by administrative, supervisory and direct service categories, by total dollars, by full-time equivalent staff

or any combination thereof, which the office may request at any time of the year, provided the office gives the hospital at least thirty days from the date of the request to provide the information.**]**

Sec. 6. Section 19a-645 of the general statutes is repealed and the following is substituted in lieu thereof:

A nonprofit hospital, licensed by the Department of Public Health, which provides lodging, care and treatment to members of the public, and which wishes to enlarge its public facilities by adding contiguous land and buildings thereon, if any, the title to which it cannot otherwise acquire, may prefer a complaint for the right to take such land to the superior court for the judicial district in which such land is located, provided such hospital shall have received the approval of the Office of Health Care Access under section 19a-639. **[**or 19a-640.**]** Said court shall appoint a committee of three disinterested persons, who, after examining the premises and hearing the parties, shall report to the court as to the necessity and propriety of such enlargement and as to the quantity, boundaries and value of the land and buildings thereon, if any, which they deem proper to be taken for such purpose and the damages resulting from such taking. If such committee reports that such enlargement is necessary and proper and the court accepts such report, the decision of said court thereon shall have the effect of a judgment and execution may be issued thereon accordingly, in favor of the person to whom damages may be assessed, for the amount thereof; and, on payment thereof, the title to the land and buildings thereon, if any, for such purpose shall be vested in the complainant, but such land and buildings thereon, if any, shall not be taken until such damages are paid to such owner or deposited with said court, for such owner's use, within thirty days after such report is accepted. If such application is denied, the owner of the land shall recover costs of the applicant, to be taxed by said court, which may issue execution therefor. Land so taken shall be held by such hospital and used only for the public purpose stated in its complaint to the superior court. No land dedicated or otherwise reserved as open space or park land or for

other recreational purposes and no land belonging to any town, city or borough shall be taken under the provisions of this section.

Sec. 7. Subsections (a), (b) and (c) of section 19a-646 of the general statutes are repealed and the following is substituted in lieu thereof:

(a) As used in this section:

(1) "Office" means the Office of Health Care Access;

(2) "Fiscal year" means the hospital fiscal year as used for purposes of this chapter;

(3) "Hospital" means any **[**short-term acute care general**]** hospital licensed by the Department of Public Health in the state;

(4) "Payer" means any person, legal entity, governmental body or eligible organization covered by the provisions of 42 USC Section 1395mm(b), or any combination thereof, except for Medicare and Medicaid which is or may become legally responsible, in whole or in part for the payment of services rendered to or on behalf of a patient by a hospital. Payer also includes any legal entity whose membership includes one or more payers and any third-party payer; **[**and**]**

(5) "Prompt payment" means payment made for services to a hospital by mail or other means on or before the tenth business day after receipt of the bill by the payer; and

(6) "Published prices, rates or charges" means a list of all prices, rates or charges which a hospital produces in hard copy for a hospital fiscal year prior to the start of such fiscal year and any subsequent additions and changes made to such list after the start of such fiscal year. At the option of the hospital, any such published list of prices, rates or charges may also be kept as part of a computer data base, provided, once published or made available to the public as an official list, each such list shall be dated as to the date of publication and such list shall be protected from subsequent changes. Each such published

list, regardless of format, paper or electronic, may only be revised by publishing a subsequent supplemental list of added or changed prices, rates or charges.

(b) (1) No hospital shall provide a discount from **[**the filed**]** its published prices, rates or charges to any payer except as provided in this section.

(2) Each hospital shall maintain at least one official copy of its annual published prices, rates or charges, and any addenda or changes to the original published prices, rates or charges, for at least five years after the close of the hospital's fiscal year or until all bills based thereon are no longer in collection or due to the hospital, whichever is longer. Each such published prices, rates or charges, and any addendum or changes thereto, shall be stamped with the date and time it was produced and when it is to be effective. A hospital may publish any number of such addenda or changes, provided each such addenda or change is properly date stamped as to its publication date and effective date. All such published prices, rates or charges, and any addendum or changes thereto, shall be available for inspection by the office, the public, a patient or a patient's authorized representative, at no charge. A hospital may request up to one business day's advance notice of such inspection in order to locate the proper list or lists. Any request for such inspection made by the office shall be complied with within one business day. Any request for such inspection made by individual patients or their representatives shall have precedence over inspection requests made by third party payers and shall be complied with within three business days.

(3) If a hospital elects to electronically post its published prices, rates or charges on the Internet or a hospital web site, such posting shall include the publication and effective dates required under subdivision (2) of this subsection. If a hospital's published prices, rates or charges are posted on the Internet or a hospital web site, the hospital need not make a copy thereof available for inspection at the hospital for such

time as the published prices, rates or charges are available on the Internet or a hospital web site, except that the office shall have the right to inspect hard copies of such published prices, rates or charges upon one business day's notice. If a hospital posts its published prices, rates or charges on the Internet or a hospital web site, the hospital shall post a notice, in the business office and all patient admitting areas, indicating that the published prices, rates or charges are available on the Internet or a hospital web site and that a hard copy is available upon request. Such notice shall include the Internet or hospital web site address and shall be in the same format as a notice posted in accordance with subdivision (1) of subsection (b) of section 19a-509b.

(c) (1) Until September 30, 1993, in addition to procedures available to other private third-party payers, an eligible organization, as described in 42 USC Section 1395mm(b), may directly negotiate for a different rate and method of reimbursement with a hospital.

(2) Effective October 1, 1993, to March 31, 1994, inclusive, an eligible organization, as described in 42 USC Section 1395mm(b), may directly negotiate for a different rate and method of reimbursement with a hospital provided (A) the cost of such discount is not shifted, in whole or in part, to other payers not so covered by the discount agreement; and (B) the charges and payment for the payer are reported in accordance with this subsection.

(3) On and after April 1, 1994, any payer may directly negotiate for a different rate and method of reimbursement with a hospital from the hospital's published prices, rates or charges, provided the charges and payments for the payer are reported by the hospital in accordance with this subsection. No discount agreement or agreement for a different rate or method of reimbursement, or amended agreement, shall be effective until filed with the office.

(4) On and after April 1, 1994, the charges and payments for each payer receiving a discount shall be accumulated by the hospital for each payer and reported as required by the office. The office may

require a review by the hospital's independent auditor, at the hospital's expense, to determine compliance with subdivision (3) of this subsection.

(5) A full written copy of each agreement executed pursuant to this subsection, on and after October 2, 1991, shall be filed with the Office of Health Care Access by each hospital executing such an agreement, no later than ten business days after such agreement is executed. Each agreement filed shall specify on its face that it was executed and filed pursuant to this subsection. Agreements filed in accordance with this subsection shall be considered trade secrets pursuant to subdivision (5) of subsection (b) of section 1-210 except that the office may utilize and distribute data derived from such agreements, including the names of the parties to the agreement, the duration and dates of the agreement and the estimated value of any discount or alternate rate of payment.

Sec. 8. Section 19a-654 of the general statutes is repealed and the following is substituted in lieu thereof:

The Office of Health Care Access shall require hospitals to submit such data, including discharge data, as it deems necessary **[**for budget review purposes**]** to fulfill the statutory responsibilities of the office. Such data shall include data taken from medical record abstracts and hospital bills. The timing and format of such submission shall be specified by the office. The data may be submitted through a contractual arrangement with an intermediary. If the data is submitted through an intermediary, the hospital shall ensure that such submission is timely and that the data is accurate. The office may conduct an audit of the data submitted to such intermediary in order to verify its accuracy. Individual patient and physician data identified by proper name or personal identification code submitted pursuant to this section shall be kept confidential, but aggregate reports from which individual patient and physician data cannot be identified shall be available to the public.

Sec. 9. Subdivision (6) of section 19a-655 of the general statutes is

repealed and the following is substituted in lieu thereof:

(6) The revenue caps established in this section shall not be increased except as provided in accordance with the provisions of sections 19a-657, **[**19a-658,**]** 19a-660, as amended by this act, 19a-663, 19a-664 and 19a-665.

Sec. 10. Section 19a-659 of the general statutes is repealed and the following is substituted in lieu thereof:

As used in sections 19a-659 to 19a-662, inclusive, 19a-669 to 19a-672, inclusive, **[**and 19a-674 to 19a-680, inclusive**]** 19a-676, 19a-677 and 19a-679, as amended by this act:

(1) "Office" means the Office of Health Care Access;

(2) "Hospital" means a hospital included within the definition of health care facilities or institutions under section 19a-630 and licensed as a short-term general hospital by the Department of Public Health and including John Dempsey Hospital of The University of Connecticut Health Center;

(3) "Fiscal year" means the hospital fiscal year;

(4) "Base year" means the fiscal year prior to the fiscal year for which a budget is being determined;

(5) "Affiliate" means a person, entity or organization controlling, controlled by, or under common control with another person, entity or organization;

(6) "Uncompensated care including emergency assistance to families" means the actual cost in the year prior to the base year of care written off as bad debts or provided free under a free care policy approved by the office including emergency assistance to families authorized by the Department of Social Services and not otherwise funded;

(7) "Medical assistance" means medical assistance provided under the general assistance program, the state-administered general assistance program or the Medicaid program;

(8) "CHAMPUS" means the federal Civilian Health and Medical Program of the Uniformed Services, 10 USC 1071 et seq.;

(9) "Medicare shortfall" means the Medicare underpayment for the year prior to the base year divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, and uncompensated care including emergency assistance to families and contractual and other allowances for the year prior to the base year;

(10) "Medical assistance shortfall" means the medical assistance underpayment for the year prior to the base year divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, and uncompensated care including emergency assistance to families and contractual and other allowances for the year prior to the base year;

(11) "CHAMPUS shortfall" means the CHAMPUS underpayment for the year prior to the base year divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, and uncompensated care including emergency assistance to families and contractual and other allowances for the year prior to the base year;

(12) "Primary payer" means the payer responsible for the highest percentage of the charges on the case;

(13) "Case mix index" means a hospital's case mix index calculated using the medical record abstract and billing data submitted by the hospital to the office. The case mix index shall be calculated by dividing the total case mix adjusted discharges for the hospital by the actual number of discharges for the hospital for the fiscal year. The total case mix adjusted discharges shall be calculated by multiplying the number of discharges in each diagnosis related group by the

Medicare weights in effect for the same diagnosis related group in effect for the fiscal year and adding the resultant procedures across all diagnosis related groups;

(14) "Contractual allowances" means, for the period October 1, 1992, to March 30, 1994, inclusive, the amount of discounts provided to nongovernmental payers pursuant to subsections (d) and (e) of section 19a-646, and for the period beginning April 1, 1994, the amount of discounts provided to nongovernmental payers pursuant to subsections (c), (d) and (e) of section 19a-646, as amended by this act;

(15) "Medicare underpayment" means the difference between the actual net revenue of a hospital times the ratio of Medicare charges to total charges and the amount received by the hospital from the federal government for Medicare patients for the year prior to the base year;

(16) "Medical assistance underpayment" means the difference between the actual net revenue of a hospital times the ratio of medical assistance charges to total charges and the amount received by the hospital from the Department of Social Services for the year prior to the base year;

(17) "CHAMPUS underpayment" means the difference between the actual net revenue of a hospital times the ratio of CHAMPUS charges to total charges and the amount received by the hospital from CHAMPUS for the year prior to the base year;

(18) "Other allowances" means the amount of any difference between charges for employee self-insurance and related expenses determined using the hospital's overall relationship of costs to charges;

(19) "Gross revenue" means the total charges for all patient care services;

(20) "Net revenue" means total gross revenue less contractual allowance, the difference between government charges and government payments, uncompensated care, and other allowances;

plus, for purposes of compliance, net payments from the uncompensated care pool in existence prior to April 1, 1994, and payments from the Department of Social Services;

(21) "Emergency assistance to families" means assistance to families with children under the age of twenty-one who do not have the resources to independently provide the assistance needed to avoid the destitution of the child and which is authorized by the Department of Social Services pursuant to section 17b-107 and is not otherwise funded.

Sec. 11. Section 19a-660 of the general statutes is repealed and the following is substituted in lieu thereof:

The office is authorized to adjust its orders in effect for fiscal year 1992 and subsequent fiscal years by order and without a prior hearing as necessary to implement the provisions of sections 19a-643 and 19a-649 and in compliance with the formulas specified herein and as necessary to implement sections 19a-659, as amended by this act, 19a-670 to 19a-672, inclusive, **[**and 19a-674 to 19a-680, inclusive**]** 19a-676, 19a-677 and 19a-679, as amended by this act. Any hospital which claims that a formula was improperly calculated or applied may request a hearing in a writing that states the hospital's position with regard to the issues to be heard, within ten days of the notice of the payment factors. Any such hearing shall be limited to the issues of whether the formula was improperly calculated or applied. Any hospital which claims that office action reduces the hospital's authorized revenue other than as necessary for the implementation of said sections and sections 19a-659, as amended by this act, 19a-670 to 19a-672, inclusive, **[**and 19a-674 to 19a-680, inclusive**]** 19a-676, 19a-677 and 19a-679, as amended by this act, and in compliance with the formulas specified in said sections may request a hearing in a writing that states the hospital's position with regard to the issues to be heard. The office shall hold a hearing on said claim.

Sec. 12. Section 19a-668 of the general statutes is repealed and the

following is substituted in lieu thereof:

Notwithstanding section 19a-667, the Office of Health Care Access may maintain or enter into any contract or contracts with one or more private entities within available appropriations to deactivate, audit or consult on any rights, duties or obligations owed to the uncompensated care pool prior to April 1, 1994, to assist the Department of Social Services and to assist in the administration of sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, subsection (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414, and sections 19a-646, as amended by this act, 19a-659 to 19a-662, inclusive, **[**and**]** 19a-666 to **[**19a-680**]** 19a-673, inclusive, 19a-676, 19a-677 and 19a-679, as amended by this act, on or after April 1, 1994.

Sec. 13. Section 19a-669 of the general statutes is repealed and the following is substituted in lieu thereof:

Effective October 1, 1993, and October first of each subsequent year, the Secretary of the Office of Policy and Management shall determine and inform the Office of Health Care Access of the maximum amount of disproportionate share payments and emergency assistance to families eligible for federal matching payments under the Medical Assistance Program or the Emergency Assistance to Families Program pursuant to federal statute and regulations and subdivisions (2) and (28) of section 12-407, subsection (1) of section 12-408, subdivision (5) of section 12-412, section 12-414, sections 19a-649, 19a-660 and 19a-661 and this section and the actual and anticipated appropriation to the medical assistance disproportionate share-emergency assistance account authorized pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, subsection (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414 and sections 19a-646, as amended by this act, 19a-659 to 19a-662, inclusive, **[**and**]** 19a-666 to **[**19a-680**]** 19a-673, inclusive, 19a-676, 19a-677 and 19a-679, as amended by this act,

and the amount of emergency assistance to families' payments to hospitals projected for the year, and the anticipated amount of any increase in payments made pursuant to any resolution of any civil action pending on April 1, 1994, in the United States district court for the district of Connecticut. The Department of Social Services shall inform the office of any amount of uncompensated care which the Department of Social Services determines is due to a failure on the part of the hospital to register patients for emergency assistance to families, or a failure to bill properly for emergency assistance to families' patients. If during the course of a fiscal year the Secretary of the Office of Policy and Management determines that these amounts should be revised, **[**he**]** the secretary shall so notify the office and the office may modify its calculation pursuant to section 19a-671, as amended by this act, to reflect such revision and its orders in accordance with section 19a-660, as amended by this act, as it deems appropriate and the Commissioner of Social Services may modify **[**his**]** the commissioner's determination pursuant to section 19a-671, as amended by this act.

Sec. 14. Subsection (d) of section 19a-670 of the general statutes is repealed and the following is substituted in lieu thereof:

(d) Nothing in section 3-114i, subdivisions (2) or (29) of section 12-407, subsection (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414, or sections 12-263a to 12-263e, inclusive, **[**sections**]** 19a-646, as amended by this act, 19a-659 to 19a-662, **[**or**]** inclusive, 19a-666 to **[**19a-680**]** 19a-673, inclusive, 19a-676, 19a-677 or 19a-679, as amended by this act, or sections 1, 2, or 38 of public act 94-9* shall be construed to require the Department of Social Services to pay out more funds than are appropriated pursuant to said sections.

Sec. 15. Section 19a-670b of the general statutes is repealed and the following is substituted in lieu thereof:

Nothing in section 12-263a, subsection (28) of section 12-407, section 19a-670, as amended by this act, or section 19a-670a **[**or 19a-676a**]** shall

be construed as relieving any children's general hospital from any prior year's disproportionate share settlements or adjustments.

Sec. 16. Section 19a-671 of the general statutes is repealed and the following is substituted in lieu thereof:

The Commissioner of Social Services is authorized to determine the amount of payments pursuant to sections 19a-670 to 19a-672, inclusive, for each hospital. The commissioner's determination shall be based on the advice of the office and the application of the calculation in this section. For each hospital, the Office of Health Care Access shall calculate the amount of payments to be made pursuant to sections 19a-670 to 19a-672, inclusive, as follows:

(1) For the period April 1, 1994, to June 30, 1994, inclusive, and for the period July 1, 1994, to September 30, 1994, inclusive, the office shall calculate and advise the Commissioner of Social Services of the amount of payments to be made to each hospital as follows:

(A) Determine the amount of pool payments for the hospital, including grants approved pursuant to section 19a-168k of the general statutes, revision of 1958, revised to January 1, 1995, in the previously authorized budget authorization for the fiscal year commencing October 1, 1993.

(B) Calculate the sum of the result of subparagraph (A) of this subdivision for all hospitals.

(C) Divide the result of subparagraph (A) of this subdivision by the result of subparagraph (B) of this subdivision.

(D) From the anticipated appropriation to the medical assistance disproportionate share-emergency assistance account made pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, subsection (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414 and sections 19a-646, 19a-659 to 19a-662, inclusive, and 19a-666 to 19a-

680, inclusive, of the general statutes, revision of 1958, revised to January 1, 2001, for the quarter subtract the amount of any additional medical assistance payments made to hospitals pursuant to any resolution of or court order entered in any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut, and also subtract the amount of any emergency assistance to families payments projected by the office to be made to hospitals in the quarter.

(E) The disproportionate share payment shall be the result of subparagraph (D) of this subdivision multiplied by the result of subparagraph (C) of this subdivision.

(2) For the fiscal year commencing October 1, 1994, and subsequent fiscal years, the interim payment shall be calculated as follows for each hospital:

(A) For each hospital determine the amount of the medical assistance underpayment determined pursuant to section 19a-659, plus the actual amount of uncompensated care including emergency assistance to families determined pursuant to section 19a-659, less any amount of uncompensated care determined by the Department of Social Services to be due to a failure of the hospital to enroll patients for emergency assistance to families, plus the amount of any grants authorized pursuant to the authority of section 19a-168k of the general statutes, revision of 1958, revised to January 1, 1995.

(B) Calculate the sum of the result of subparagraph (A) of this subdivision for all hospitals.

(C) Divide the result of subparagraph (A) of this subdivision by the result of subparagraph (B) of this subdivision.

(D) From the anticipated appropriation made to the medical assistance disproportionate share-emergency assistance account pursuant to sections 3-114i and 12-263a to 12-263e, inclusive,

subdivisions (2) and (29) of section 12-407, subsection (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414 and sections 19a-646, as amended by this act, 19a-659 to 19a-662, inclusive, **[**and**]** 19a-666 to **[**19a-680**]** 19a-673, inclusive, 19a-676, 19a-677 and 19a-679, as amended by this act, for the fiscal year, subtract the amount of any additional medical assistance payments made to hospitals pursuant to any resolution of or court order entered in any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut, and also subtract any emergency assistance to families payments projected by the office to be made to the hospitals for the year.

(E) The disproportionate share payment shall be the result of subparagraph (D) of this subdivision multiplied by the result of subparagraph (C) of this subdivision.

Sec. 17. Section 19a-672 of the general statutes is repealed and the following is substituted in lieu thereof:

The funds appropriated to the medical assistance disproportionate share-emergency assistance account pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, subsection (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414 and sections 19a-646, as amended by this act, 19a-659 to 19a-662, inclusive, **[**and**]** 19a-666 to **[**19a-680**]** 19a-673, inclusive, 19a-676, 19a-677 and 19a-679, as amended by this act, shall be used by said account to make disproportionate share payments to hospitals, including grants to hospitals pursuant to section 19a-168k of the general statutes, revision of 1958, revised to January 1, 1995, and to make emergency assistance to families payments to hospitals. In addition, the medical assistance disproportionate share-emergency assistance account may utilize a portion of these funds to make outpatient payments as the Department of Social Services determines appropriate or to increase the standard medical assistance payments to hospitals if the Department of Social

Services determines it to be appropriate to settle any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut. Notwithstanding any other provision of the general statutes, the Department of Social Services shall not be required to make any payments pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, subsection (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414 and sections 19a-646, as amended by this act, 19a-659 to 19a-662, inclusive, **[**and**]** 19a-666 to **[**19a-680**]** 19a-673, inclusive, 19a-676, 19a-677 and 19a-679, as amended by this act, in excess of the funds available in the medical assistance disproportionate share-emergency assistance account.

Sec. 18. Section 19a-673 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section:

(1) "Cost of providing services" means a hospital's published charges at the time of billing of an uninsured patient, multiplied by the hospital's most recent relationship of costs to charges as taken from the hospital's most recently available audited financial statements.

(2) "Hospital" means an institution licensed by the Department of Public Health as a **[**short-term general**]** hospital.

(3) "Poverty income guidelines" means the poverty income guidelines issued from time to time by the United States Department of Health and Human Services.

(4) "Uninsured patient" means any person whose income is at or below two hundred per cent of the poverty income guidelines who (A) has applied and been denied eligibility for any medical or health care coverage provided under the general assistance program or the Medicaid program due to failure to satisfy income or other eligibility requirements, and (B) is not eligible for coverage for hospital services

under the Medicare or CHAMPUS programs, or under any Medicaid or health insurance program of any other nation, state, territory or commonwealth, or under any other governmental or privately sponsored health or accident insurance or benefit program including, but not limited to, workers' compensation and awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

(b) No hospital that has provided health care services to an uninsured patient may collect from the uninsured patient more than the cost of providing services.

Sec. 19. Section 19a-679 of the general statutes is repealed and the following is substituted in lieu thereof:

[(a) For purposes of calculating the hospital's net revenue limit for the fiscal year commencing October 1, 1994, and subsequent fiscal years, the authorized number of equivalent discharges shall be:

(1) For a hospital exempt from detailed budget review the authorized equivalent discharges shall be the actual number of equivalent discharges in the year prior to the base year.

(2) For a hospital subject to partial budget review the authorized equivalent discharges shall be the actual number of equivalent discharges in the year prior to the base year plus the authorized number of equivalent discharges associated with the approved certificate of need project or projects for which partial review is requested.**]**

[(b)**]** (a) Each hospital shall submit to the Office of Health Care Access inpatient and outpatient gross revenues and units of service separately for each hospital revenue center. For the fiscal years commencing October 1, 1993, and October 1, 1994, the units of service may be determined by the hospital. The office shall specify a standard list of units of service for use by each hospital in the fiscal year

commencing October 1, 1995. For the fiscal year commencing October 1, 1995, hospitals shall report units of service based on both the list used in the fiscal year commencing October 1, 1994, and the standard list specified by the office for use in the fiscal year commencing October 1, 1995. For fiscal years commencing on and after October 1, 1996, all hospitals shall report units of service based exclusively on the standard list specified by the office, for use in the fiscal year commencing October 1, 1995. The timing and format of the submissions shall be specified by the office. In addition for the fiscal year commencing October 1, 1994, and subsequent fiscal years, these data shall be submitted on at least a quarterly basis in conjunction with the medical record abstract and billing data specified in **[**subsection (b) of**]** section 19a-654, as amended by this act. The revenue centers shall be specified by the office.

[(c)**]** (b) (1) For the fiscal year commencing October 1, 1994, "equivalent discharges" shall be defined as follows: The number of discharges for the fiscal year commencing October 1, 1992, times the ratio of the total gross revenue to the inpatient gross revenue for the same year. For compliance purposes for the fiscal year commencing October 1, 1993, the number of equivalent discharges shall be the actual number of discharges in the fiscal year commencing October 1, 1993, multiplied by the actual ratio of the total gross revenue to inpatient gross revenue for the first six months of the fiscal year commencing October 1, 1993. For compliance purposes for the fiscal year commencing October 1, 1994, the number of equivalent discharges shall be the actual number of discharges in the fiscal year commencing October 1, 1994, multiplied by the ratio of the total gross revenue to inpatient gross revenue specified in the budget authorization for the fiscal year commencing October 1, 1994.

(2) For the fiscal years commencing October 1, 1995, and October 1, 1996, "equivalent discharges" shall be defined as follows:

(A) For each revenue center providing services to outpatients, each

outpatient unit of service shall be converted into a fraction of a discharge. The fraction shall be the ratio of the revenue per unit of service in the revenue center to the inpatient revenue per inpatient discharge for the fiscal year commencing October 1, 1993.

(B) The number of outpatient equivalent discharges generated by the revenue center for the fiscal year shall be the product of the outpatient units of service for the revenue center for the fiscal year times the fraction calculated in subparagraph (A) of this subdivision for the revenue center for the fiscal year.

(C) The total number of outpatient equivalent discharges for the fiscal year for the hospital shall be the sum of all calculations pursuant to subparagraph (B) of this subdivision across all revenue centers. The total number of equivalent discharges for the hospital shall be defined as the number of outpatient equivalent discharges plus the number of inpatient discharges.

Sec. 20. Section 19a-681 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each hospital shall include all applicable taxes in the price of each item in its pricemaster for each charge.

(b) If the billing detail by line item does not agree with the **[**detailed**]** published schedule of charges **[**on file with the Office of Health Care Access**]** for the date of service specified on the bill, the hospital shall have fifteen business days from the date the hospital receives written notice of such discrepancy to provide a corrected bill with the lesser of the billed or published charges. For the failure to correct a bill in accordance with this section, the hospital shall be subject to a civil penalty of five hundred dollars per occurrence payable to the state within ten business days of notification. The penalty shall be imposed in accordance with subsections (b) to (e), inclusive, of section 19a-653. **[**The office may issue an order requiring such hospital, within ten business days of notification of an overcharge to a patient, to adjust the

bill to be consistent with the schedule of charges on file with the office for the date of service specified on the patient bill.**]**

Sec. 21. Section 4-101a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The Office of Health Care Access, in consultation with the Office of Policy and Management, may provide grants, technical assistance or consultation services, or any combination thereof, to one or more nongovernmental acute care general hospitals as permitted by this section. Such grants, technical assistance or consultation services shall be consistent with applicable federal disproportionate share regulations, as from time to time amended.

(b) Grants, technical assistance or consultation services, or any combination thereof, provided under this section may be made to assist a nongovernmental acute care general hospital to develop and implement a plan to achieve financial stability and assure the delivery of appropriate health care services in the service area of such hospital, to assist in the collection of outpatient and inpatient data, or to assist a nongovernmental acute care general hospital in determining strategies, goals and plans to ensure its financial viability or stability. Any such hospital seeking such grants, technical assistance or consultation services shall prepare and submit to **[**the Office of Policy and Management and**]** the Office of Health Care Access a plan that includes at least the following: (1) A statement of the hospital's current projections of its finances for the current and the next three fiscal years; (2) identification of the major financial issues which effect the financial stability of the hospital; (3) the steps proposed to study or improve the financial status of the hospital and eliminate ongoing operating losses; (4) plans to study or change the mix of services provided by the hospital, which may include transition to an alternative licensure category; and (5) other related elements as determined by the Office of **[**Policy and Management**]** Health Care Access. Such plan shall clearly identify the amount, value or type of the grant, technical assistance or

consultation services, or combination thereof, requested. Any grants, technical assistance or consultation services, or any combination thereof, provided under this section shall be determined by the Secretary of the Office of Policy and Management not to jeopardize the federal matching payments under the medical assistance program and the emergency assistance to families program as determined by the Office of Health Care Access or the Department of Social Services in consultation with the Office of Policy and Management.

(c) There is established a nonlapsing account, from which grants, purchases of services of any type or reimbursement of state costs for services deemed necessary by the Office of Policy and Management and the Office of Health Care Access to assist one or more nongovernmental acute care general hospitals under this section shall be made.

(d) The submission of a proposed plan by the hospital under subsection (b) of this section may be considered a letter of intent for the purposes of any certificate of need which may be required to change the hospital's service offering.

(e) Upon review and approval of the probable significant benefit of a hospital's submitted plan, the Office of **[**Policy and Management**]** Health Care Access may recommend that a grant be awarded and issue such grant, or contract with one or more consultants to provide technical or other assistance or consultation services, or may provide any combination of such grant and assistance that the office deems necessary or advisable.

Sec. 22. Subsection (a) of section 17b-242 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The Department of Social Services shall determine the rates to be paid to home health care agencies and homemaker-home health aide agencies by the state or any town in the state for persons aided or cared for by the state or any such town. For the period from February

1, 1991, to January 31, 1992, inclusive, payment for each service to the state shall be based upon the rate for such service as determined by the Office of Health Care Access, except that for those providers whose Medicaid rates for the year ending January 31, 1991, exceed the median rate, no increase shall be allowed. For those providers whose rates for the year ending January 31, 1991, are below the median rate, increases shall not exceed the lower of the prior rate increased by the most recent annual increase in the consumer price index for urban consumers or the median rate. In no case shall any such rate exceed the eightieth percentile of rates in effect January 31, 1991, nor shall any rate exceed the charge to the general public for similar services. Rates effective February 1, 1992, shall be based upon rates as determined by the Office of Health Care Access, except that increases shall not exceed the prior year's rate increased by the most recent annual increase in the consumer price index for urban consumers and rates effective February 1, 1992, shall remain in effect through June 30, 1993. Rates effective July 1, 1993, shall be based upon rates as determined by the Office of Health Care Access pursuant to the provisions of subsection (b) of section 19a-635 <u>of the general statutes, revision of 1958, revised to January 1, 2001</u>, except if the Medicaid rates for any service for the period ending June 30, 1993, exceed the median rate for such service, the increase effective July 1, 1993, shall not exceed one per cent. If the Medicaid rate for any service for the period ending June 30, 1993, is below the median rate, the increase effective July 1, 1993, shall not exceed the lower of the prior rate increased by one and one-half times the most recent annual increase in the consumer price index for urban consumers or the median rate plus one per cent. The Commissioner of Social Services shall establish a fee schedule for home health services to be effective on and after July 1, 1994. The commissioner may annually increase any fee in the fee schedule based on an increase in the cost of services. The commissioner shall increase the fee schedule for home health services provided under the Connecticut home-care program for the elderly established under section 17b-342, effective July 1, 2000, by two per cent over the fee schedule for home health

services for the previous year. The commissioner may increase any fee payable to a home health care agency or homemaker-home health aide agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health care; (3) escort services; or (4) extended hour services. In no case shall any rate or fee exceed the charge to the general public for similar services. A home health care agency or homemaker-home health aide agency which, due to any material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days of implementing the policies and procedures. Such policies and procedures shall be valid for not longer than nine months.

Sec. 23. Section 17b-856 of the general statutes is repealed and the following is substituted in lieu thereof:

The Department of Social Services may provide grants to hospitals to pay for outreach and eligibility determinations for assistance to families. For the fiscal years ending June 30, 1994, and June 30, 1995, the sum of two million dollars appropriated to the department may be used for said grants and for fiscal years ending June 30, 1996, and subsequent fiscal years, such amount shall be adjusted to reflect the aggregate of inflation in authorized hospital gross revenues determined pursuant to **[**sections 19a-648 and**]** section 19a-649.

Sec. 24. Subsection (a) of section 19a-1c of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Whenever the words "Commissioner of Public Health and Addiction Services" are used or referred to in the following sections of the general statutes, the words "Commissioner of Public Health" shall be substituted in lieu thereof and whenever the words "Department of Public Health and Addiction Services" are used or referred to in the following sections of the general statutes, the words "Department of Public Health" shall be substituted in lieu thereof: 1-21b, 2-20a, 3-129, 4-5, 4-38c, 4-60i, 4-67e, 4a-12, 4a-16, 4a-51, 5-169, 7-22a, 7-41a, 7-42, 7-44, 7-45, 7-47a, 7-48, 7-49, 7-51, 7-52, 7-53, 7-54, 7-55, 7-56, 7-59, 7-60, 7-62a, 7-62b, 7-62c, 7-65, 7-70, 7-72, 7-73, 7-74, 7-127e, 7-504, 7-536, 8-159a, 8-206d, 8-210, 10-19, 10-71, 10-76d, 10-203, 10-204a, 10-207, 10-212, 10-212a, 10-214, 10-215d, 10-253, 10-282, 10-284, 10-292, 10a-132, 10a-155, 10a-162a, 12-62f, 12-263a, 12-407, 12-634, 13a-175b, 13a-175ee, 13b-38n, 14-227a, 14-227c, 15-121, 15-140r, 15-140u, 16-19z, 16-32e, 16-43, 16-50c, 16-50d, 16-50j, 16-261a, 16-262l, 16-262m, 16-262n, 16-262o, 16-262q, 16a-36, 16a-36a, 16a-103, 17-585, 17a-20, 17a-52, 17a-154, 17a-219c, 17a-220, 17a-277, 17a-509, 17a-688, 17b-6, 17b-99, 17b-225, 17b-234, 17b-265, 17b-288, 17b-340, 17b-341, 17b-347, 17b-350, 17b-351, 17b-354, 17b-357, 17b-358, 17b-406, 17b-408, 17b-420, 17b-552, 17b-611, 17b-733, 17b-737, 17b-748, 17b-803, 17b-808, 17b-851a, 19a-1d, 19a-4i, 19a-6, 19a-6a, 19a-7b, 19a-7c, 19a-7d, 19a-7e, 19a-7f, 19a-7g, 19a-7h, 19a-9, 19a-10, 19a-13, 19a-14, 19a-14a, 19a-14b, 19a-15, 19a-17, 19a-17a, 19a-17m, 19a-17n, 19a-19, 19a-20, 19a-21, 19a-23, 19a-24, 19a-25, 19a-25a, 19a-26, 19a-27, 19a-29, 19a-29a, 19a-30, 19a-30a, 19a-32, 19a-32a, 19a-33, 19a-34, 19a-35, 19a-36, 19a-36a, 19a-37, 19a-37a, 19a-37b, 19a-40, 19a-41, 19a-42, 19a-43, 19a-44, 19a-45, 19a-47, 19a-48, 19a-49, 19a-50, 19a-51, 19a-52, 19a-53, 19a-54, 19a-55, 19a-56a, 19a-56b, 19a-57, 19a-58, 19a-59, 19a-59a, 19a-59b, 19a-59c, 19a-59d, 19a-60, 19a-61, 19a-69, 19a-70, 19a-71, 19a-72, 19a-73, 19a-74, 19a-75, 19a-76, 19a-79, 19a-80, 19a-82 to 19a-91, inclusive, 19a-92a, 19a-93, 19a-94, 19a-94a, 19a-102a, 19a-103, 19a-104, 19a-105, 19a-108, 19a-109, 19a-110, 19a-110a, 19a-111, 19a-111a, 19a-111e, 19a-112a, 19a-112b, 19a-112c, 19a-113, 19a-113a, 19a-115, 19a-116,

19a-121, 19a-121a, 19a-121b, 19a-121c, 19a-121d, 19a-121e, 19a-121f, 19a-122b, 19a-123d, 19a-124, 19a-125, 19a-148, 19a-175, 19a-176, 19a-178, 19a-179, 19a-180, 19a-181a, 19a-182, 19a-183, 19a-184, 19a-186, 19a-187, 19a-195a, 19a-200, 19a-201, 19a-202, 19a-204, 19a-207, 19a-208, 19a-215, 19a-219, 19a-221, 19a-223, 19a-229, 19a-241, 19a-242, 19a-243, 19a-244, 19a-245, 19a-250, 19a-252, 19a-253, 19a-255, 19a-257, 19a-262, 19a-269, 19a-270, 19a-270a, 19a-279l, 19a-310, 19a-311, 19a-312, 19a-313, 19a-320, 19a-323, 19a-329, 19a-330, 19a-331, 19a-332, 19a-332a, 19a-333, 19a-341, 19a-401, 19a-402, 19a-406, 19a-409, 19a-420, 19a-421, 19a-422, 19a-423, 19a-424, 19a-425, 19a-426, 19a-427, 19a-428, 19a-490, 19a-490c, 19a-490d, 19a-490e, 19a-490g, 19a-491, 19a-491a, 19a-491b, 19a-492, 19a-493, 19a-493a, 19a-494, 19a-494a, 19a-495, 19a-496, 19a-497, 19a-499, 19a-500, 19a-501, 19a-503, 19a-504, 19a-504c, 19a-505, 19a-506, 19a-507a, 19a-507b, 19a-507c, 19a-507d, 19a-508, 19a-509a, 19a-512, 19a-514, 19a-515, 19a-517, 19a-518, 19a-519, 19a-520, 19a-521, 19a-521a, 19a-523, 19a-524, 19a-526, 19a-527, 19a-528, 19a-530, 19a-531, 19a-533, 19a-534a, 19a-535, 19a-535a, 19a-536, 19a-537, 19a-538, 19a-540, 19a-542, 19a-547, 19a-550, 19a-551, 19a-554, 19a-581, 19a-582, 19a-584, 19a-586, 19a-630, 19a-631, 19a-634, 19a-637, 19a-638, 19a-639, 19a-645, 19a-646, 19a-663, 19a-673, [19a-675,] 20-8, 20-8a, 20-9, 20-10, 20-11, 20-11a, 20-11b, 20-12, 20-12a, 20-13, 20-13a, 20-13b, 20-13d, 20-13e, 20-14, 20-14j, 20-27, 20-28a, 20-28b, 20-29, 20-37, 20-39a, 20-40, 20-45, 20-54, 20-55, 20-57, 20-58a, 20-59, 20-66, 20-68, 20-70, 20-71, 20-73, 20-73a, 20-74, 20-74a, 20-74i, 20-74aa, 20-74dd, 20-86b, 20-86c, 20-86d, 20-86f, 20-86h, 20-90, 20-92, 20-93, 20-94, 20-94a, 20-96, 20-97, 20-99, 20-99a, 20-101a, 20-102aa to 20-102ee, inclusive, 20-103a, 20-106, 20-107, 20-108, 20-109, 20-110, 20-114, 20-122a, 20-122b, 20-122c, 20-123a, 20-126b, 20-126h, 20-126j, 20-126k, 20-126l, 20-126o, 20-126p, 20-126q, 20-126r, 20-126u, 20-127, 20-128a, 20-129, 20-130, 20-133, 20-138a, 20-138c, 20-139a, 20-140a, 20-141, 20-143, 20-146, 20-146a, 20-149, 20-153, 20-154, 20-162n, 20-162p, 20-188, 20-189, 20-190, 20-192, 20-193, 20-195a, 20-195m, 20-195p, 20-196, 20-198, 20-199, 20-200, 20-202, 20-206, 20-206a, 20-206m, 20-206p, 20-207, 20-211, 20-212, 20-213, 20-214, 20-217, 20-218, 20-220, 20-221, 20-222, 20-222a, 20-223, 20-224, 20-226, 20-227, 20-228, 20-229, 20-231, 20-235a, 20-236,

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Sec. 25. The unexpended balance of funds appropriated to the Office of Health Care Access under special act 99-10 for the purposes of a distressed hospitals loan program and transferred to the hospital grant and assistance program in the Office of Policy and Management established pursuant to section 4-101a of the general statutes, shall be transferred to the Office of Health Care Access and shall not lapse.

Sec. 26. Sections 19a-635, 19a-636, 19a-640, 19a-648, 19a-650, 19a-651, 19a-658, 19a-674, 19a-675, 19a-676a, 19a-678 and 19a-680 of the general

statutes are repealed.

Sec. 27. This act shall take effect July 1, 2001.

Statement of Purpose:

To implement the Governor's budget recommendations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]